Report on an announced inspection visit to police custody suites and court cells in the

Cayman Islands

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by

HM Inspectorate of Prisons

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1. Introduction

The Cayman Islands are a self-governing British Overseas Territory comprising three islands in the Caribbean. In January 2012, HM Inspectorate of Prisons received a formal letter from the Governor of the islands (who has responsibility for internal security) inviting an inspection of the Cayman Islands custodial facilities. The focus of this inspection were the Royal Cayman Island Police Service (RCIPS) custody suites at George Town, West Bay and Bodden Town as well as the courts cells in George Town. We were unable to visit the cells on Cayman Brac although we understand them to be new and in good condition.

In conducting our inspection, we used our usual inspection methodology and criteria but took a pragmatic approach to our Expectations and took account of potential cultural and contextual differences between Cayman and the UK. We also compared services in the custody facilities with services in the Cayman community where relevant.

The condition of the police custody suites at George Town and West Bay were extremely poor. We describe them as dirty, windowless and hot. There were numerous safety issues and they were barely fit for human habitation. We were reassured that senior officers of police agreed with us, that they should be condemned and replaced as soon as possible.

Systems to support improvements were almost completely lacking. There were no agreed standards to work to, little data were retained or analysed and staff training was very limited. Partnership working with other interested Island agencies hardly existed. Much that was in place to ensure the proper treatment and care of detainees, including women and young people, was informal, subject to too much unregulated discretion and lacking in effective oversight and accountability. Arrangements to provide health care were similarly crude and unaccountable.

Most of the themes we identified in police custody facilities applied equally to the court custody facility in George Town. Facilities there were also poor, but of particular concern was the lack of effective joint working between agencies with responsibilities in the suite.

Urgent improvements need to be made to custody facilities operated by both RCIPS and court services in Cayman. It is difficult to see how this will be achieved without significant investment and a radical review of governance structures. The report's findings confirm my view that all custodial facilities need to be subject to regular independent inspection to ensure even the most basic human rights standards are upheld and meaningful accountability maintained. The absence of such arrangements in the Cayman Islands was a significant factor in the very poor conditions we found in this one-off inspection. My report provides a small number of important recommendations that could assist.

Nick Hardwick
HM Chief Inspector of Prisons **September 2012**

Police custody inspection

2. Background and main findings

2.1 In England and Wales, police custody is inspected jointly by HM Inspectorates of Prisons and Constabulary, while HM Inspectorate of Prisons inspects court custody facilities. These inspections form part of the joint work programme of the criminal justice inspectorates and contribute to the UK's response to its international obligations under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) – which monitor the treatment of and conditions for detainees. HM Inspectorates of Prisons and Constabulary are two of several bodies making up the NPM in the UK.

2.2 The Cayman Islands, a British Overseas Territory, are not a signatory in their own right to the Optional Protocol, which means that areas of detention on the islands are not subject to regular independent monitoring. HMIP was invited by the Governor of the Islands to undertake inspections of both police and court custody consistent with our inspections in England and Wales.

2.3 The inspections of police custody look beyond police law and guidance. They are informed by a set of *Expectations for Police Custody*[1] about the appropriate treatment of detainees and conditions of detention, developed by the two inspectorates to assist best custodial practice. Court custody inspections have their own set of *Expectations*, which describe the standards of treatment and conditions that we expect each court custody suite to achieve for people in its custody, grouped under three inspection areas: leadership, strategy and planning; individual rights; and treatment and conditions.

2.4 At the time of the inspection, Royal Cayman Islands Police Service (RCIPS) had a total of seven police stations, four of which had custody facilities, including Cayman Brac, which we did not visit.

2.5 The custody facilities were located as follows:

Police station	Number of cells
George Town	16
West Bay	5
Bodden Town	1
Cayman Brac	2

2.6 HMIP researchers and inspectors carried out a survey of 10 prisoners at HMP Northward who had formerly been detained in RCIPS custody facilities to obtain additional evidence.

[1] http://www.justice.gov.uk/inspectorates/hmi-prisons/expectations.htm

Strategy

2.7 There was a senior lead for custody, of sufficient rank, with a management structure beneath. However, there were no agreed standards or policies/guidelines against which the quality of police custody could be assessed. Not all staff regularly working in custody were trained to do so. Systems for ensuring constructive feedback from incidents and 'lessons learnt' were informal and ineffectively shared. Formal partnership working with other agencies in the form of agreed protocols or regular meetings to discuss issues relevant to custody did not exist.

Treatment and conditions

2.8 George Town and West Bay custody suites were not fit for purpose, They were dirty, windowless, hot and humid, with no air conditioning, except in staff areas. Cells contained obscene and gang-related graffiti and multiple ligature points, and there were no secure exercise yards. Detainees held there had no privacy. By comparison, the cell at Bodden Town was reasonable and we understood that Cayman Brac had a relatively new suite of two cells.

2.9 Some efforts were made to keep juveniles and women separate from others, by using the whole of the custody 'estate' but there was no awareness of how to meet their specific needs or the needs of other minority groups, such as those with disabilities or other vulnerabilities. There was no evidence of pre-release assessments in custody records, and the use of force was not recorded or reviewed, to ensure accountability.

2.10 In spite of some efforts by officers, overall care was below our expected standards. Little was provided by the police, but this was mitigated by the fact that family members could provide bedding, clothing and toiletries. Detainees could also receive visits. We found a lack of consistency in the care provided, and one 'protected witness', who had been in isolation for over a month, had no access to fresh air and natural light and no way of telling the time of day.

2.11 The quality of entries in the custody records was poor, often reporting only the food provided; in one case the record appeared more like an account of the ongoing investigation, rather than the care of the detainee. There was no obvious dip-sampling of custody records for quality assurance.

Individual rights

2.12 Most detainees were not told their rights on arrival. Appropriate criteria were used to decide to admit to custody but we found detainees who had been kept for long periods in police cells without resolution by a court. There was little evidence of reviews by senior officers.

2.13 There was no structured appropriate adult scheme for the interview of young or vulnerable people but when required they were recruited from their families or social services. However, there were some concerns about the availability of social services staff out of hours.

2.14 There was no formal or guaranteed provision of free legal advice but some local law firms offered a limited pro bono service. Custody records were not available to legal representatives without a court order.

2.15 The complaint process was not adequately explained to detainees and was not easily accessed. There were no effective systems for the handling of forensic samples and DNA.

Health care

2.16 Health care was not provided in custody and was wholly reliant on officers recognising issues and escorting the detainee to hospital. There were major risks associated with regard to substance use withdrawal. Not all staff were first-aid trained; first-aid kits were provided but were basic. Some detainees were not able to receive prescribed medications. Mental health services were only available *in extremis*, when symptoms were recognised; however, staff had not received any mental health awareness training.

Main recommendations

2.17 **The United Kingdom should extend OPCAT to the Cayman Islands.**

2.18 **There should be a strategic focus on custody that includes closing and replacing the existing custody suites to ensure a clean and decent environment in which detainees' safety is protected and their multiple and diverse needs are met. There should be custody-specific policies and procedures to protect the well-being of detainees against which the quality of care and services can be assessed.**

3. Strategy

Expected outcomes:
There is a strategic focus on custody that drives the development and application of custody specific policies and procedures to protect the wellbeing of detainees.

3.1 A chief inspector was the senior lead for custody; she was supported by an inspector, who was the custody manager. There were no agreed standards or policies/guidelines against which the quality of police custody could be assessed or monitored. Steps were being taken to rectify this situation and there was a draft RCIPS custody policy being written, which was to be critiqued by the Cayman Islands Human Rights Commission. However, at the time of the inspection staff had to rely on 'common sense' and custom and practice. This meant that standards of care for detainees were not consistent and there were clear examples of poor and unregulated discretion being used that had a negative impact on the care of detainees.

3.2 The main police station in George Town and the station at West Bay had both been condemned some time before the inspection but were still in use. The custody suites were appalling and not fit for purpose. There were no definite plans to replace them, although we were told that there had been some preliminary discussions. The one cell at Bodden Town police station was reasonable by comparison.

3.3 In George Town there were four custody sergeants, each of whom worked with two auxiliary constables; they each worked 12-hour shifts, so provided some continuity. This was not the case at the other police stations, where staff were relocated to the custody suite when required. Not all staff regularly working in custody were trained to work there. We met one auxiliary constable in George Town who told us that he had received no formal training, and he had resorted to watching clips on 'YouTube' about custody in the USA to learn how to care for detainees.

3.4 There was no recording process for adverse incidents that occurred in RCIPS custody, and systems for ensuring constructive feedback from incidents and 'lessons learnt' were informal and ineffectively shared. We were told that there was 'dip-sampling' of custody records but found no evidence to support this claim. Health and safety checks were not recorded and we doubted whether they were actually carried out.

3.5 Closed-circuit television (CCTV) was not available in all police stations and, where it was installed, it had limited coverage and did not include custody cells. The tapes were not downloaded and only recorded on a continuous loop for a maximum of six days.

3.6 Custody records were paper based, and only a basic data set was then recorded on to an electronic system which was part of the Overseas Territories police electronic system.

3.7 The Prison Inspection Board (PIB) made regular visits to the custody suites but their reports were perfunctory. The police only responded to the PIB if they stated that something was 'unsatisfactory', and there was no dialogue between the two organisations.

3.8 Formal partnership working with other agencies, such as the courts administration, immigration or health services, in the form of protocols or regular meetings to discuss issues relevant to custody, did not exist.

Recommendations

3.9 **There should be specific policies that establish clear standards of care for those detained in police custody. Standards should address all issues, but as a minimum include accommodation and environment, supervision, the management of risk, equality and diversity and health.**

3.10 **Policies, adverse incidents and lessons learnt from other police jurisdictions should be used for the monitoring of custody facilities and services and to ensure accountability.**

3.11 **All staff who work in custody should be trained to do so.**

3.12 **There should be closed-circuit television in all areas of custody. Images should be kept for at least 30 days.**

3.13 **There should be protocols and regular meetings with all agencies concerned with the detention and care of police detainees to develop, maintain and improve services.**

4. Treatment and conditions

Expected outcomes:
Detainees are held in a clean and decent environment in which their safety is protected and their multiple and diverse needs are met.

Respect

4.1 In our survey, only one detainee said that he had been treated well by staff while he was in custody. Seven said that they had been treated badly or very badly. One detainee told us, *'We just need people who care'*.

4.2 The booking-in area at George Town was in a separate area to the cells and some efforts had been made to ensure privacy; however, we observed people waiting in seats in the area while the booking-in of others was being conducted. At West Bay, detainees were either booked in at the front desk or taken into an open office area, which was inappropriate. There were no private facilities for booking in at Bodden Town.

4.3 Some staff made efforts to keep juveniles and women separate from others by using the whole of the custody 'estate'. However, staff at West Bay told us that they always transferred women and juveniles to George Town, while staff at George Town said that West Bay was used for juveniles if there were adults at George Town. We found evidence of a woman who had been held at Bodden Town for the whole of her time in custody but, generally, there was no awareness of how or why women needed to be treated differently from male detainees, for example, providing them with a female officer to speak to in private. It was obvious that George Town was used to hold the majority of detainees. It was close to the courts, so even if detainees were kept at one of the other custody suites, they were likely to be moved to George Town on the day before any court hearings.

4.4 The diverse needs of other groups (such as those with disabilities), dependency needs and other obvious vulnerabilities were also not taken into account; most staff we spoke to were not able to describe what they would do for such detainees. The custody manager assured us that they would manage, but we were not assured that this was so.

Recommendations

4.5 **There should be clear policies about how to manage the diverse needs of detainees, such as women, juveniles and those with disabilities, with which all staff working in custody should be familiar.**

4.6 **Women should be able to speak to a female officer on arrival and at any time they request to do so.**

Safety

4.7 The custody risk assessment was perfunctory. We did not see any detainees being booked in, but we were not assured from custody records that risks were identified and dealt with when identified, or that they were updated in light of any new information. Custody records were brief and often only detailed the various meals that detainees had been given rather than any other information about when the detainee had been checked, or their safety or well-being. One

record we reviewed seemed to be more of an account of the detainee's ongoing case investigation than their care in custody. There was no obvious dip-sampling of custody records for quality assurance.

4.8 We found no evidence of pre-release assessments and often the custody record finished abruptly, with no reference to the outcome of the detainee's time in custody.

4.9 Three detainees in our survey alleged that they had been abused by police while in their custody, and one that he had been sprayed with mace. No applications of force used in custody were recorded or reviewed, and there were no systems to manage, monitor or ensure accountability.

Recommendations

4.10 **The initial booking-in process should include information about potential risks, and custody records should include all interactions with the detainee, including regular rousing to ensure detainee safety.**

4.11 **There should be formal pre release assessment processes so that the Royal Cayman Islands Police Service (RCIPS) is assured that all detainees being released are able to get home safely and, for those being transferred to other criminal justice agencies, relevant information about risk or vulnerabilities is passed on.**

4.12 **The RCIPS should record all uses of force in custody and then monitor them by ethnicity, nationality, age, location and officers involved, in line with good practice.**

Physical conditions

4.13 Neither George Town nor West Bay custody suites were fit for purpose. The doors and walls took the form of a mesh, giving the appearance of cages rather than cells. As a result, there were multiple ligature points (see photograph, Appendix II). A further adverse consequence of the open nature of cells was that detainees were visible to others and at risk of verbal abuse and threats. Most of the cells were for double or multiple occupancy. The cells at West Bay were particularly small, although during the inspection the cell doors were open and detainees were able to associate with others. The bunk beds comprised metal shelf-like units. Both suites were dirty, windowless and had no natural light; George Town in particular was oppressively hot and humid, with no air conditioning (although there was air conditioning in the staff areas). Detainees put towels up at the air vents and put their mattresses on the floor in an attempt to deflect any fresh air that came through the vents on to them as they lay on the mattresses. We found examples of gang-related, obscene and biblical graffiti on the walls and doors. In our survey, 100% of men said that the temperature was bad and 60% that the lighting was bad too.

4.14 Each suite had showers and toilets, which were dirty and not suitably screened to provide any privacy. In our survey, only two men said that they could use the toilet when they wanted to, and 60% that they were not given the opportunity to have a shower. However, as none of the cells had a call bell and staff were not able to see the cells from their offices, it was not clear how any detainee attracted the attention of staff to request anything.

4.15 There were no secure exercise yards. At George Town, detainees were sometimes taken into the car park in handcuffs and shackles for some fresh air or to smoke. No one in our survey had been offered any outdoor exercise.

4.16 We were told that there had been a recent fire evacuation at George Town owing to a fire in a cell, but no evacuation practices had been held at West Bay. Staff at George Town showed us that there were not enough sets of handcuffs for each prisoner if the suite was full.

4.17 There were six cells in a separate area to the main custody cells at George Town, which we were told were used for women and juveniles. They were some distance from the other cells and it was not clear how often anyone checked on detainees when they were used. At the time of the inspection there was a protected witness being held in them, who had been in isolation for over a month. The door to his cell was left open so that he could also use the corridor, but his cell and the corridor were dark, with no natural light. He had no way of telling what time of day it was, had not been outside for several weeks and was clearly depressed.

4.18 The single cell at Bodden Town was reasonable. There was no bed, merely a mattress on the floor, but there was a stained toilet and a sink screened from the door; it had a window and benefited from its position next to the main office, which had air conditioning. We were told that Cayman Brac had a relatively new suite of two cells, but we did not visit it.

Recommendations

4.19 **Cells should be free from ligature points and graffiti. They should be clean, have natural light, be at a comfortable temperature and have a call bell. They should be for single use only.**

4.20 **Custody staff should rouse detainees regularly if needed, and record that they have done so in the detainee's custody records.**

4.21 **The RCIPS should carry out regular fire evacuation practices of the whole custody suite, to ensure that staff are aware of their roles and responsibilities.**

Detainee care

4.22 Detainees were given little care by the RCIPS while they were in custody. Families were expected to provide clothing, bedding, toiletries and reading materials. Food was provided by a catering company three times a day; the food we saw was cold and unappetising. Families often brought food in for the detainees. We were not assured that custody staff would know what to do if a detainee did not have any family or friends to provide for him or her.

4.23 The police facilitated visits for detainees, irrespective of their length of time in custody or their age. However, there was little documentary evidence of how the decision to allow visits was made and we were not assured that the discretion used by some officers was replicated by others.

Recommendation

4.24 **Detainees should be provided with clothing, bedding, toiletries, reading materials and decent food from the RCIPS and not need to rely on family and friends.**

5. Individual rights

Expected outcomes:
Detainees are informed of their individual rights on arrival and can freely exercise those rights while in custody.

Rights relating to detention

5.1 Custody sergeants told us that they ensured that detention was only used when necessary and that they requested detailed accounts from arresting officers to establish that lawful procedures had been followed. In George Town, the sergeant was able to provide anecdotal accounts of when he had refused detention because of insufficient evidence to arrest the detainee and when detention had been requested for a non-arrestable offence. There was little evidence of reviews by senior officers.

5.2 The decision to grant police bail was mainly related to the seriousness of the offence and took into account the risk to the public and likelihood of continued offending. Although we found that the rules regarding reviews of detention and application for extension had been followed, many detainees we met had been in police cells for several days. One had been arrested on a Thursday, not charged in time for court on Friday and was due to appear in court on the following Tuesday.

5.3 We were unable to observe the booking-in of a newly arrested detainee but we saw the process used with a man answering bail. In custody records, a checklist was completed for detainees which indicated that they were offered a free telephone call and asked if they wished to contact a lawyer. In George Town, we saw a prominent notice, in three languages, which was a brief statement of prisoners' rights, and the detainee answering bail was directed to read it; however, there was no such notice at the other custody suites. There was no evidence from our observations or from custody records that detainees' understanding of their rights was checked, although they were required to sign that they had been informed of them. In our survey, seven of the 10 detainees interviewed could not recollect being informed of their rights.

5.4 Immigration detainees were held for long periods at George Town. We were told that they were regularly held for more than a month awaiting deportation, and there had been a recent case of three Cuban detainees who had conducted a dirty protest.

5.5 We saw custody records which indicated that police cells were routinely used as a place of safety for juveniles. There was no appropriate adult scheme for detained juveniles or vulnerable adults that might guarantee individual support. Custody records however, showed that family members were available in most cases and we were told that social services staff were on call at all times, although we were also told of delays in them attending out of hours.

5.6 Independent interpreting services were not easily available. Police staff who spoke Spanish and Filipino were regularly used. Interpreters for other languages had to be sourced through national consulates.

Recommendations

5.7 **Custody staff should check that detainees understand their rights, and record this.**

5.8 **Immigration detainees held in police cells should be transferred immediately to immigration services detention.**

5.9 **Police cells should not be used as a place of safety for juveniles or vulnerable adults.**

5.10 **Independent interpreting services should be readily available.**

Rights relating to police law

5.11 There was no routine provision of free legal representatives, although we were told that some local lawyers offered a *pro bono* service. In West Bay, there was no suitable area for private consultation with legal advisers but in George Town and Bodden Town there were suitable rooms for this.

5.12 Only one detainee told us that he had been offered free legal advice, and one that he had had a lawyer present during his interview with the police. Custody records were not routinely made available to legal representatives and we were told that a copy would only be provided if ordered by a court.

5.13 There was no effective system for monitoring and ensuring that forensic samples were promptly transported to the central laboratory. We found urine samples in a refrigerator at West Bay that had been taken three weeks previously.

Recommendations

5.14 **Free legal representation should be offered to all detainees, and police interviews should not be conducted without the availability of legal advice.**

5.15 **Detainees should be able to consult with legal advisers in privacy in a suitable room.**

5.16 **Custody records should be freely available to legal representatives.**

5.17 **A forensic samples management system should be established to ensure that samples are sent to the forensic laboratory promptly.**

Rights relating to treatment

5.18 Detainees were not told how to make a complaint; if a prisoner wanted to do so, he was first directed to the custody inspector and then to the Professional Standards Department. We did not see any evidence of complaints that had been made. In spite of the serious allegations that detainees made to us, they did not appear to have an understanding of how to make a complaint or any confidence that it would be addressed.

5.19 Not all areas of the custody suite were covered by CCTV; in addition, the tapes were not downloaded, and were used to record on a continuous loop for a maximum of six days. Given that detainees were often in custody for seven days or more, this meant that there was no way for any allegations or complaints made after they had left the custody suite to be investigated thoroughly using CCTV footage.

Recommendation

5.20 **Transparent procedures should be introduced that enable detainees to make a complaint about their treatment if necessary before leaving custody and receive a response within an acceptable time. This right should be explained to them on arrival, and again before they leave.**

6. Health care

Expected outcomes:
Detainees have access to competent health care professionals who meet their physical health, mental health and substance use needs in a timely way.

Patient care

6.1 There were no health services provided in custody. Detainees were wholly reliant on officers recognising issues and escorting them to hospital in George Town. In our survey, no one had been told that they could see a health care professional if they wanted to, and only one respondent had been seen. The Health Services Authority charged the RCIPS for all treatment given to detainees, which had the potential to cause a conflict of interest. The bill for April 2012 indicated that 11 detainees had been treated. We found evidence that in some cases prescribed medication following a hospital attendance was given, but in our survey none of the three men on medication before arrest were able to receive it while in custody.

6.2 Staff were not all first-aid trained. First-aid kits were provided but were basic.

Recommendations

6.3 **There should be a service level agreement or memorandum of understanding between the Health Services Authority and the RCIPS to ensure that detainees receive appropriate health care while in custody, irrespective of costs.**

6.4 **Detainees should be able to receive prescribed medication while in custody.**

6.5 **All staff who work in custody should have first-aid and resuscitation training and have access to the necessary equipment in the police station.**

Substance use

6.6 The RCIPS had not had any training in how to recognise withdrawal from drugs or alcohol. In our survey, four men said that they had drug or alcohol problems, but none had been offered the chance to see a support worker.

6.7 There was a drug referral court in George Town, referral to which was voluntary. We were told that custody staff did not always obtain a urine sample for a drugs test, even if the offence was drug related. The samples were tested at the local hospital and we were told of delays in obtaining test results; this meant that the case could not progress, as the results were required by the court before the case could proceed. We met one man in custody who had requested to appear before the drugs court. He had already spent six days in police custody and was then remanded to prison for a further week before going to court.

Recommendation

6.8 **All custody staff should be trained and able to recognise the signs and symptoms of withdrawal from drugs or alcohol and take appropriate action.**

Mental health

6.9 Mental health services were only available *in extremis*, by taking the detainee to the local hospital, when symptoms were recognised; however, staff had not received any mental health awareness training.

Recommendation

6.10 **All custody staff should have mental health awareness training.** .

7. Summary of recommendations – Police cells

Main recommendations

7.1 The United Kingdom should extend OPCAT to the Cayman Islands. (2.17)

7.2 There should be a strategic focus on custody that includes closing and replacing the existing custody suites to ensure a clean and decent environment in which detainees' safety is protected and their multiple and diverse needs are met. There should be custody-specific policies and procedures to protect the well-being of detainees against which the quality of care and services can be assessed. (2.18)

Recommendations

Strategy

7.3 There should be specific policies that establish clear standards of care for those detained in police custody. Standards should address all issues, but as a minimum include accommodation and environment, supervision, the management of risk, equality and diversity and health. (3.9)

7.4 Policies, adverse incidents and lessons learnt from other police jurisdictions should be used for the monitoring of custody facilities and services and to ensure accountability. (3.10)

7.5 All staff who work in custody should be trained to do so. (3.11)

7.6 There should be closed-circuit television in all areas of custody. Images should be kept for at least 30 days. (3.12)

7.7 There should be protocols and regular meetings with all agencies concerned with the detention and care of police detainees to develop, maintain and improve services. (3.13)

Treatment and conditions

7.8 There should be clear policies about how to manage the diverse needs of detainees, such as women, juveniles and those with disabilities, with which all staff working in custody should be familiar. (4.5)

7.9 Women should be able to speak to a female officer on arrival and at any time they request to do so. (4.6)

7.10 The initial booking-in process should include information about potential risks, and custody records should include all interactions with the detainee, including regular rousing to ensure detainee safety. (4.10)

7.11 There should be formal pre release assessment processes so that the Royal Cayman Islands Police Service (RCIPS) is assured that all detainees being released are able to get home safely and, for those being transferred to other criminal justice agencies, relevant information about risk or vulnerabilities is passed on. (4.11)

7.12 The RCIPS should record all uses of force in custody and then monitor them by ethnicity, nationality, age, location and officers involved, in line with good practice. (4.12)

7.13 Cells should be free from ligature points and graffiti. They should be clean, have natural light, be at a comfortable temperature and have a call bell. They should be for single use only. (4.19)

7.14 Custody staff should rouse detainees regularly if needed, and record that they have done so in the detainee's custody records. (4.20)

7.15 The RCIPS should carry out regular fire evacuation practices of the whole custody suite, to ensure that staff are aware of their roles and responsibilities. (4.21)

7.16 Detainees should be provided with clothing, bedding, toiletries, reading materials and decent food from the RCIPS and not need to rely on family and friends. (4.24)

Individual rights

7.17 Custody staff should check that detainees understand their rights, and record this. (5.7)

7.18 Immigration detainees held in police cells should be transferred immediately to immigration services detention. (5.8)

7.19 Police cells should not be used as a place of safety for juveniles or vulnerable adults. (5.9)

7.20 Independent interpreting services should be readily available. (5.10)

7.21 Free legal representation should be offered to all detainees, and police interviews should not be conducted without the availability of legal advice. (5.14)

7.22 Detainees should be able to consult with legal advisers in privacy in a suitable room. (5.15)

7.23 Custody records should be freely available to legal representatives. (5.16)

7.24 A forensic samples management system should be established to ensure that samples are sent to the forensic laboratory promptly. (5.17)

7.25 Transparent procedures should be introduced that enable detainees to make a complaint about their treatment if necessary before leaving custody and receive a response within an acceptable time. This right should be explained to them on arrival, and again before they leave. (5.20)

Health care

7.26 There should be a service level agreement or memorandum of understanding between the Health Services Authority and the RCIPS to ensure that detainees receive appropriate health care while in custody, irrespective of costs. (6.3)

7.27 Detainees should be able to receive prescribed medication while in custody. (6.4)

7.28 All staff who work in custody should have first-aid and resuscitation training and have access to the necessary equipment in the police station. (6.5)

7.29 All custody staff should be trained and able to recognise the signs and symptoms of withdrawal from drugs or alcohol and take appropriate action. (6.8)

7.30 All custody staff should have mental health awareness training. (6.10)

8. Court cells inspection

Introduction

8.1 As part of HMIP's inspection of custody facilities in the Cayman Islands, we inspected court custody facilities.

8.2 The courts in George Town were under the remit of the Chief Justice of the Cayman Islands. There were no separate court custodians; the police and Prison Service staff worked alongside each other, acting as custodians of their respective charges.

8.3 We found the facilities to be cramped and lacking in privacy. Detainees were potentially subject to abuse and assault because they had to pass through public areas on arrival at the custody suite and, in some cases, when making their way to court.

8.4 The recommendations that we have made will need to be considered and put into action by all the agencies involved if outcomes for those held in court custody are to be improved.

Leadership, strategy and planning

8.5 The court buildings were the responsibility of the Judicial Administration, as part of the overall remit of the Chief Justice of the Cayman Islands. The court services, prisons and police all had specific roles in the care and control of detainees at court. Although there were operating procedures and practices in use, there was no written protocol to define the role and responsibilities of the respective organisations in terms of the care of detainees in custody, and there were no formal meetings between all the parties involved.

8.6 We were told of some disagreements between the parties, in relation to the escorting of newly convicted detainees to prison. The Prison Service was of the opinion that it was the responsibility of the police to transport all newly convicted detainees, irrespective of whether they had arrived at court under arrest. The police took the view that the Prison Service should take responsibility for detainees once they had been convicted. In reality, there was nowhere to hand over the care of convicted detainees safely within the court custody area, but the issue clearly caused animosity between the parties involved.

8.7 Although there were facilities for conducting court hearings remotely by video conferencing, they had never been used.

Recommendations

8.8 **The roles and responsibilities of the organisations delivering court custodial services should be clearly set out in a written service level agreement.**

8.9 **Court hearings should be conducted by video link where possible.**

Individual rights

8.10 A record was kept of the authorisation for detention at court and we found that detainees were quickly returned to police custody or prison after their court cases had been heard.

8.11 Facilities for consulting legal representatives were poor. We saw detainees talking to legal counsel in preparation for their court appearance through the bars of their detention rooms in the presence of staff and other detainees. Legal counsel we spoke to told us that dedicated private interview rooms were not available and that they had to make use of the counsel's robing room, which was liable to interruption from other counsel using the facility.

8.12 If interpreters were needed, they were usually arranged by the police.

8.13 Detainees were not told how to make a complaint about court detention and relied on police and prison complaints systems.

Recommendations

8.14 **Detainees should have facilities and sufficient time for private interviews with counsel.**

8.15 **Detainees should have access to the means for complaining about court detention.**

Treatment and conditions

Respect

8.16 Detainees were transported short distances to the court from police or prison custody. Prison vehicles were suitable and clean, with compartments to separate women and juveniles from adult male detainees. Police transport was in police cars, with juveniles, adult males and women being transported separately.

8.17 There was no area around the court to facilitate embarkation and disembarkation in private. Detainees had to disembark from vehicles in a public car park next to the court, usually in handcuffs and sometimes in shackles. This exposed them to the potential for abuse and assault. In order to access two of the courts in the main building, and those in a nearby courthouse, detainees were required to pass through public areas.

8.18 Food was provided for detainees at appropriate mealtimes by the organisation responsible for them. This meant that it had to be brought from the prison or the police station, so it sometimes needed reheating. Staff were on hand to provide drinking water on request.

Safety

8.19 Because detention in the court custody facilities was the responsibility of whichever organisation had brought the detainee to court, supervision and care was managed in the same way as it was in the prison or police custody. This meant that there was little documented evidence of needs assessments or care provided.

8.20 There were no specific facilities for the support of young people being taken to custody, other than keeping them separate from adults.

8.21 All detainees were kept under constant supervision by staff in the corridor and there was CCTV covering the area.

Physical conditions

8.22 Detainees were held in rooms off a narrow corridor. Each had a bench around three walls and an iron grille front. There were three such holding rooms and we were told that one was used specifically for women and juveniles. There was graffiti on the walls of detention rooms, some proclaiming gang loyalties, but they were generally clean. The area was air conditioned so the temperature was reasonable but there was little natural light.

8.23 During the inspection, none of the cells were overcrowded but staff told us that they often had to put eight or nine detainees into one cell. This would have resulted in cramped conditions and insufficient room for everyone to sit down.

8.24 There were toilets with hand-washing facilities.

Health care

8.25 There were no health care facilities within the court custody suite. If a detainee needed health care, he or she was taken to the hospital in George Town by their custodian.

Recommendations

8.26 **Food provided for detainees should be fresh and at the correct temperature.**

8.27 **Detainees should not be required to pass through public areas on their way into or between courts.**

8.28 **Holding rooms should be cleaned of graffiti.**

8.29 **There should be sufficient cell space to provide privacy and reasonable space for each detainee.**

9. Summary of recommendations – Court cells

Recommendations

Leadership, strategy and planning

9.1 The roles and responsibilities of the organisations delivering court custodial services should be clearly set out in a written service level agreement. (8.8)

9.2 Court hearings should be conducted by video link where possible. (8.9)

Individual rights

9.3 Detainees should have facilities and sufficient time for private interviews with counsel. (8.14)

9.4 Detainees should have access to the means for complaining about court detention. (8.15)

Treatment and conditions

9.5 Food provided for detainees should be fresh and at the correct temperature. (8.26)

9.6 Detainees should not be required to pass through public areas on their way into or between courts. (8.27)

9.7 Holding rooms should be cleaned of graffiti. (8.28)

9.8 There should be sufficient cell space to provide privacy and reasonable space for each detainee. (8.29)

Appendix I: Inspection team

Elizabeth Tysoe	Team leader
Andrew Rooke	Inspector
Laura Nettleingham	Senior researcher
Rachel Murray	Researcher

Appendix II: Photograph

Cell in George Town police station

Appendix III: Summary of detainee questionnaires and interviews

Detainee survey methodology

A voluntary, confidential and anonymous survey of the prisoner population who had been through a police station in both police stations in Grand Cayman, was carried out for this inspection. The results of this survey formed part of the evidence-base for the inspection.

Choosing the sample size

The survey was conducted on 25 –28 June 2012. At the time of the survey, all individuals at HMP Northward and HMP Fairbanks were being surveyed as part of a full inspection of both prisons. Individuals were offered a police custody survey where possible.[2].

Completion of the questionnaire was voluntary. Interviews were offered to any respondents with literacy difficulties. No respondents required an interview.

Methodology

Every questionnaire was distributed to each respondent individually. This gave researchers an opportunity to explain the independence of the Inspectorate and the purpose of the questionnaire, as well as to answer questions.

All completed questionnaires were confidential – only members of the Inspectorate saw them. In order to ensure confidentiality, respondents were asked to do one of the following:

- to fill out the questionnaire immediately and hand it straight back to a member of the research team;
- have their questionnaire ready to hand back to a member of the research team at a specified time; or
- to seal the questionnaire in the envelope provided and leave it in their room for collection.

Response rates

In total, 10 respondents completed and returned their questionnaires.

Comparisons

Due to the differential nature of Caymanian police custody suites, no comparisons with existing English data were conducted.

[2] Researchers routinely select a sample of prisoners held in police custody suites within the last two months. Where numbers are insufficient to ascertain an adequate sample, the time limit is extended up to six months. The survey analysis continues to provide an indication of perceptions and experiences of those who have been held in these policy custody suites over a longer period of time.

Summary

A summary of the survey results is attached. This shows a breakdown of responses for each question. Percentages have been rounded and therefore may not add up to 100%.

No questions have been filtered within the summary so all percentages refer to responses from the entire sample. The percentages to certain responses within the summary, for example 'Not held over night' options across questions, may differ slightly. This is due to different response rates across questions, meaning that the percentages have been calculated out of different totals (all missing data are excluded). The actual numbers will match up, as the data are cleaned to be consistent.

Percentages shown in the summary may differ by 1% or 2 % from that shown in the comparison data, as the comparator data have been weighted for comparison purposes.

Survey results

Section 1: About you

Q2 **Which police station were you last held at?**
George Town (10)

Q3 **How old are you?**

16 years or younger	1 (10%)	*40-49 years*	0 (0%)
17-21 years	2 (20%)	*50-59 years*	0 (0%)
22-29 years	4 (40%)	*60 years or older*	0 (0%)
30-39 years	3 (30%)		

Q4 **Are you:**

Male	10 (100%)
Female	0 (0%)
Transgender/transsexual	0 (0%)

Q5 **What is your ethnic origin?**

White	0 (0%)
Black	5 (50%)
Asian	0 (0%)
Mixed race	5 (50%)
Other ethnic group	0 (0%)

Q6 **Are you a Caymanian?**

Yes	10 (100%)
No	0 (0%)

Q7 **What region are you from?**

Africa	0 (0%)
North America	0 (0%)
Central America	0 (0%)
South America	0 (0%)
Indian subcontinent (India, Pakistan, Bangladesh, Sri-Lanka)	0 (0%)
China	0 (0%)
Other Asia	0 (0%)
Caribbean	10 (100%)
Europe	0 (0%)
Middle East	0 (0%)
Other	0 (0%)

Q8 **What, if any, is your religion?**

None	1 (10%)
Church of England	3 (30%)
Catholic	0 (0%)
Protestant	0 (0%)
Other Christian denomination	6 (60%)
Buddhist	0 (0%)
Hindu	0 (0%)
Jewish	0 (0%)
Muslim	0 (0%)
Sikh	0 (0%)

Q9 **How would you describe your sexual orientation?**

Straight/heterosexual	10 (100%)
Gay/lesbian/homosexual	0 (0%)
Bisexual	0 (0%)

Q10 **Do you consider yourself to have a disability?**

Yes	2 (20%)
No	8 (80%)

Q11 **Have you ever been held in police cells before?**

Yes	9 (90%)
No	1 (10%)

Section 2: Your experience of the police cells

Q12 **How long were you held at the police station?**

Less than 24 hours	1 (10%)
More than 24 hours, but less than 48 hours (2 days)	1 (10%)
More than 48 hours (2 days), but less than 72 hours (3 days)	2 (20%)
72 hours (3 days) or more	6 (60%)

Q13 **Were you told your rights when you first arrived there?**

Yes	3 (30%)
No	7 (70%)
Don't know/can't remember	0 (0%)

Q14 **If your clothes were taken away, what were you offered instead?**

My clothes were not taken	5 (50%)
I was offered a tracksuit to wear	0 (0%)
I was offered an evidence/paper suit to wear	4 (40%)
*I was **only** offered a blanket*	0 (0%)
Nothing	1 (10%)

Q15 **Could you use a toilet when you needed to?**

Yes	2 (20%)
No	8 (80%)
Don't know	0 (0%)

Q16 **If you used the toilet there, was toilet paper provided?**

Yes	8 (89%)
No	1 (11%)

Q17 **How would you rate the condition of your cell:**

	Good	*Neither*	*Bad*
Cleanliness	1 (10%)	2 (20%)	7 (70%)
Ventilation/ air quality	0 (0%)	1 (11%)	8 (89%)
Temperature	0 (0%)	0 (0%)	10 (100%)
Lighting	2 (20%)	2 (20%)	6 (60%)

Q18 **Was there any graffiti in your cell when you arrived?**

Yes	7 (70%)
No	3 (30%)

Q19 **Did your cell have a call bell?**

Yes	0 (0%)

No 10 (100%)

Q20 **Did staff explain to you the correct use of the call bell?**

Yes 0 (0%)
No 9 (100%)

Q21 **Were you held overnight?**

Yes 9 (90%)
No 1 (10%)

Q22 **If you were held overnight, which items of bedding were you given? (Please tick all that apply to you.)**

Not held overnight 1 (10%)
Pillow 0 (0%)
Blanket 0 (0%)
Nothing 9 (90%)

Q23 **If you were given items of bedding, were these clean?**

Not held overnight/did not get any bedding 10 (100%)
Yes 0 (0%)
No 0 (0%)

Q24 **Were you offered a shower at the police station?**

Yes 4 (40%)
No 6 (60%)

Q25 **Were you offered any period of outside exercise while there?**

Yes 0 (0%)
No 10 (100%)

Q26 **Were you offered anything to:**

	Yes	*No*
Eat?	9 (90%)	1 (10%)
Drink?	9 (90%)	1 (10%)

Q27 **What was the food/drink like in the police cells?**

Very good	*Good*	*Neither*	*Bad*	*Very bad*	*N/A*
0 (0%)	1 (10%)	3 (30%)	2 (20%)	3 (30%)	1 (10%)

Q28 **Was the food/drink you received suitable for your dietary requirements?**

I did not have any food or drink 1 (10%)
Yes 2 (20%)
No 7 (70%)

Q29 **Were you offered anything to read?**

Yes 0 (0%)
No 10 (100%)

Q30 **Was someone informed of your arrest?**

Yes 3 (30%)
No 6 (60%)
I don't know 1 (10%)
I didn't want to inform anyone 0 (0%)

Q31 **Were you offered a free telephone call?**

Yes 2 (20%)

No 8 (80%)

Q32 **If you were denied a free phone call, was a reason for this offered?**

My telephone call was not denied..... 4 (40%)
Yes..... 0 (0%)
No 6 (60%)

Q33 **Did you have any concerns about the following, while you were in police cells?**

	Yes	*No*
Who was taking care of your children	5 (63%)	3 (38%)
Contacting your partner, relative or friend	6 (75%)	2 (25%)
Contacting your employer	8 (80%)	2 (20%)
Where you were going once released	8 (89%)	1 (11%)

Q34 **Were you offered free legal advice?**

Yes..... 1 (10%)
No 9 (90%)

Q35 **Did you accept the offer of free legal advice?**

Was not offered free legal advice 9 (90%)
Yes..... 1 (10%)
No 0 (0%)

Q36 **Were you interviewed by police about your case?**

Yes..... 7 (70%)
No 3 (30%)

Q37 **Was a lawyer present when you were interviewed?**

Did not ask for a lawyer/was not interviewed..... 4 (40%)
Yes..... 1 (10%)
No 5 (50%)

Q38 **Was an interpreter present when you were interviewed?**

Did not need an interpreter/was not interviewed 5 (50%)
Yes..... 0 (0%)
No 5 (50%)

Section 3: Safety

Q40 **Did you feel safe there?**

Yes..... 0 (0%)
No 10 (100%)

Q41 **Did a member of staff victimise (insulted or assaulted) you there?**

Yes..... 6 (60%)
No 4 (40%)

Q42 **If you were victimised by staff, what did the incident involve? (Please tick all that apply to you.)**

I have not been victimised.....	4 (40%)	*Because of your crime*.....	5 (50%)
Insulting remarks (about you, your family or friends)	3 (30%)	*Because of your sexuality*.....	0 (0%)
Physical abuse (being hit, kicked or assaulted)	4 (40%)	*Because you have a disability*	0 (0%)

Sexual abuse	0 (0%)	*Because of your religion/religious beliefs*	2 (20%)
Your race or ethnic origin	2 (20%)	*Because you are from a different part of the island/district than others*	2 (20%)
Drugs	0 (0%)		

Q43 **Were your handcuffs removed on arrival at the police station?**

Yes	1 (10%)
No	9 (90%)
I wasn't handcuffed	0 (0%)

Q44 **Were you restrained whilst in police cells?**

Yes	4 (44%)
No	5 (56%)

Q45 **Were you injured while in police cells, in a way that was not your fault?**

Yes	4 (40%)
No	6 (60%)

Q46 **Were you told how to make a complaint about your treatment if you needed to?**

Yes	1 (10%)
No	9 (90%)

Q47 **How were you treated by staff in the police cells?**

Very well	*Well*	*Neither*	*Badly*	*Very badly*	*Don't remember*
0 (0%)	1 (10%)	2 (20%)	3 (30%)	4 (40%)	0 (0%)

Section 4: Health care

Q49 **Did someone explain your entitlements to see a health care professional if you needed to?**

Yes	0 (0%)
No	9 (90%)
Don't know	1 (10%)

Q50 **Were you seen by the following health care professionals during your time there?**

	Yes	*No*
Doctor	1 (10%)	9 (90%)
Nurse	0 (0%)	9 (100%)

Q51 **Were you able to see a health care professional of your own gender?**

Yes	1 (10%)
No	9 (90%)
Don't know	0 (0%)

Q52 **Did you need to take any prescribed medication when you were in police cells?**

Yes	3 (30%)
No	7 (70%)

Q53 **Were you able to continue taking your prescribed medication while there?**

Not taking medication	7 (70%)
Yes	0 (0%)
No	3 (30%)

Q54 **Did you have any drug or alcohol problems?**

Yes	4 (40%)
No	6 (60%)

Q55 **Did you see, or were you offered the chance to see a drug or alcohol support worker?**

I didn't have any drug/alcohol problems	6 (60%)
Yes	0 (0%)
No	4 (40%)

Q56 **Were you offered relief or medication for your immediate withdrawal symptoms?**

I didn't have any drug/alcohol problems	6 (60%)
Yes	0 (0%)
No	4 (40%)

Q57 **Please rate the quality of your health care while in police cells:**

I was not seen by health care	*Very good*	*Good*	*Neither*	*Bad*	*Very bad*
9 (90%)	0 (0%)	0 (0%)	1 (10%)	0 (0%)	0 (0%)

Q58 **Did you have any specific <u>physical</u> health care needs?**

Yes	3 (30%)
No	7 (70%)

Q59 **Did you have any specific <u>mental</u> health care needs?**

Yes	1 (10%)
No	9 (90%)

Q60 **If you had any mental health care needs, were you seen by a mental health nurse/psychiatrist?**

I didn't have any mental health care needs	9 (90%)
Yes	0 (0%)
No	1 (10%)

HM Inspectorate of Prisons is a member of the UK's National Preventive Mechanism, a group of organisations which independently monitor all places of detention to meet the requirements of international human rights law.